



NEW PATIENT REGISTRATION QUESTIONNAIRE - CHILD

Date _ _ / _ _ / _ _

To register your child with the Practice please complete this questionnaire as fully as possible before their new patient assessment. This has to be done prior to being registered.

Surname: Forename(s):

Address:

..... Postcode:

Date of Birth: Place of birth:..... Home tel:

Mobile: Tick box to signify happy to receive text messages such as reminders:

Email address:

Previous GP.....

Name of Parents & contact details: Mother.....
Father.....

School Attended.....

What Language is spoken at home ?

Ethnicity – please tick appropriate box (one box only)

- British or British Mixed Irish Other White Background White and Black Caribbean
White and Black African White and Asian Other Mixed Background Indian or British Indian
Pakistani or British Pakistani Bangladeshi or British Bangladeshi Other Asian background
Caribbean African Other Black Background Chinese
Ethnic category not stated Any other Ethnic Group

SMOKING

Does anyone at home smoke: Yes / Not Any Longer / Never

If Yes, do they want help in giving up.....

Weight (approx): **Height:**

DIET

Do you have a varied diet at home including milk, meat, vegetables and fruit? Yes / No

PAST MEDICAL HISTORY

Please give details (& dates) of any significant illnesses including hospital treatments & operations:

.....
.....

Do they have any special needs ?.....

MEDICATION

Please give details of any medication which you take (prescribed or otherwise):

Please bring your repeat request form or the containers to your first appt

Name of drugs & Dosage:
.....
.....
.....

ALLERGIES

Are they allergic to any substances or foods? Yes / No

If yes, please give details:

.....
.....

IMMUNISATIONS. These are important in order to protect against illnesses which can only be prevented by developing your child's natural immunity.

Please give details immunisations & dates which your child has had so far – including holiday jabs:

List here (Nurse will confirm) e.g.

Primary Course: Diphtheria /Tetanus /Polio /Meningitis /HIB at 2, 3 &4 mths
MMR at 13 mths.....
Pre-school Booster Diphtheria /Tetanus /Polio /MMR.....
13yrs Rubella /Giardasil
Final School boosters Tetanus /Polio /Meningitis.....
Other Immunisations

FAMILY HISTORY

Is there any of the following in their close family (*parents, grandparents, brother, sister*) before age of 65?
Heart Disease (heart attacks, angina) / Stroke / Insulin dependant diabetes / Glaucoma or Cancer (specify site) or Any other known hereditary disease ?

Condition(s) & family member(s) affected?
.....
.....

Have you any concerns about your child's health that you would like to discuss with the Doctor or Health Visitor ?

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PLEASE ASK AT RECEPTION DESK FOR DETAILS OF HEALTH VISITOR CLINICS ETC